

**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**PART I: GENERAL INFORMATION**

Requestor's Name and Address:

CROWN CHIROPRACTIC
2401 N. ARKANSAS AVE.
LAREDO, TX 78043

MFDR Tracking #:

M4-10-0231-01

Respondent Name and Box #: **54**

TEXAS MUTUAL INSURANCE CO

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: The Requestor did not submit a position summary.

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - \$300.00
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "The requestor, at the request of the treating doctor, performed MMI/IR examinations of the claimant on 7/6/09. The requestor concluded the claimant reached MMI on 7/2/09 with an IR of 0%. The requestor billed Texas Mutual CPT code 99456-WP. Texas Mutual reviewed its claim file. That review showed very little in the way of treatment. A. The compensable injury was a trip on a step causing some discomfort to the knee when the claimant grabbed a hand rail. B. The treating doctor prescribed a brace and anti-inflammatory medication. C. The requestor at the time of his evaluation found only"...left knee pain, intermittent "popping" of the left knee and intermittent swelling..." For these reasons Texas Mutual considered the injury to be minor and applied section (j)(2)(B) of Rule 134.204. Payment based on this section of the Rule is \$350.00. The requestor for his part has not shown that the injury is of sufficient nature that it is non-minor."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Part V Reference	Amount Ordered
7/6/09	99456-WP N/A	1 thru 10	\$0.00
Total:			

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and 28 TAC Section 134.204, titled *Medical Fee Guideline for Workers' Compensation Specific Services*. The Guideline shall be effective for workers' compensation specific codes, services and programs provided on or after March 1, 2008.

1. These services were denied by the Respondent with reason code "CAC-W1 workers compensation state fee schedule adjustment", "790- this charge was reimbursed in accordance to the Texas Medical Fee Guideline", "CAC-W4 no additional reimbursement allowed after review of appeal/reconsideration" and "891-the insurance company is reducing or denying payment after reconsideration".
2. The information submitted in this dispute is reviewed. The Requestor did not submit the original billing or the reconsideration billing as is required under Rule 133.307(c)(2)(A) which states in part... Provider Request. The provider shall complete the required sections of the request in the form and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).
3. The Division will move forward with a decision based on the information that is available in this dispute.
4. The Carrier's explanation of benefit (EOB) shows that the provider billed current procedural terminology (CPT) code 99456-WP in the amount of \$650.00. The Carrier paid the provider \$350.00.
5. The Provider's "Request for Reconsideration" letter is reviewed. The Provider states in part..."In the instance that the patient continues to suffer ongoing pain to not perform range of motion would be negligent. Given this fact of ongoing pain, a range of motion exam was needed to determine appropriate MMI/IR. Range of motion exam in {sic} necessitated for extremity cases in the fourth edition. Without examining the joint I could not have known whether or not to award impairment or not and to examine the joint would require a range of motion exam. Should the carrier try to deny payment due to "minor injury" and that I should not performed an exam with range of motion, I counter that claim with {sic} fact the treating doctor ordered an MRI of the left knee and that the MRI was positive for meniscus tear. This was not a "minor" injury or the TD would not have ordered such a diagnostic not to mention that the diagnostic ordered was positive...."
6. The Provider's documentation submitted in this dispute supporting the billing is reviewed. It is noted that the date of service (DOS) on the documentation is 7/2/09. The DOS on the Carrier EOB is 7/6/09. Since the Requestor did not submit any billing it is unclear to the Division what the actual DOS is.
7. Upon further review of the Provider's documentation, the finding of a meniscal tear that the Provider references in his reconsideration letter is not found in the supporting documentation. Under the physical exam portion of the documentation, the provider references range of motion of the left and right knee – see range of motion worksheet. There is no worksheet found in this dispute with range of motion findings between the left and right knee. There is however a copy of a page attached from Guides to the Evaluation of Permanent Impairment that has a handwritten non-legible note written off to the side in the left margin.
8. The documentation requirements have not been met under Rule 134.203(a)(5) which states: "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.
9. Rule 134.204(j)(2)(B) states in part...Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title. If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.
10. Therefore, for the reasons noted above, no additional reimbursement to the Requestor is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1
Texas Government Code, Chapter 2001, Subchapter G
134.204, 133.307, 133.250 and 134.203

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:_____
Authorized Signature_____
Auditor
Medical Fee Dispute Resolution11/23/09

Date**PART VIII: YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.